ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES WAIVER PROGRAM
AGENCY ATTENDANT CARE SERVICE AGREEMENT

This agreement is hereby made between

_____
(Client's Name)

_____
(Client's Medicaid ID)

a participant/client of Alternatives for Adults with Physical Disabilities Waiver Program,
an Arkansas Medicaid program administered by the Division of Aging & Adult Services,

and _____,
(Attendant Care Services Agency's Name AND PROVIDER NUMBER)

an Arkansas Medicaid Provider of Alternatives Agency Attendant Care Services.

According to regulations approved by the Center for Medicare and Medicaid Services, the participant/client and agency attendant care services provider agree to the following arrangement:

The Participant/client desires to:

[ ] have services provided by an Alternatives attendant care services agency via the "traditional agency services model;" or
[ ] function as a "participant/co-employer" (managing employer) with the Alternatives attendant care services agency.

Participant/client and agency attendant care services provider agree agency attendant care services will be provided according to the Alternatives waiver Plan of Care.

The Provider of Alternatives agency attendant care services agrees to serve:

[ ] As the Alternatives Attendant Care Services Agency via the "traditional agency services model;" or
[ ] As the Alternatives Attendant Care Services Agency through the "participant/co-employer" (managing employer) arrangement.

The provisions of this Agreement represent the entirety of the Agreement between the two parties.

This Agreement will automatically terminate one year from the date of signing by the parties or the date the certification expires, unless terminated by the participant/client earlier due to unsatisfactory Alternatives agency attendant care services provider performance.

All the information included in this Agreement has been explained, and all questions regarding information included in this Agreement have been answered to the complete satisfaction of both the participant/client and the agency attendant care services provider. A copy of this agreement will be received by us and will be retained in our records.

_____ _____
ALTERNATIVES PROGRAM CLIENT SIGNATURE DATE

_____ _____
AGENCY REPRESENTATIVE SIGNATURE DATE

_____
AGENCY'S MAILING ADDRESS

_____
CITY STATE ZIP COUNTY

Meal Preparation is hands-on assistance with tasks involved in preparing and serving a meal and cleaning articles and utensils used in the preparation. Meal preparation can **ONLY** be done for the Alternatives' participant/client. Meal preparation **CANNOT** be done for other members of the household.

Catheter Care: To be in compliance with the Nurse Practice Act, a family member, who has been trained by a medical professional to perform catheter care procedures, can perform catheter care. Therefore, **ONLY** attendant care services providers who are family members and who have been trained by a medical professional can provide catheter care for an Alternatives participant/client.

Medication Assistance: To be in compliance with the Nurse Practice Act, a family member who is the Alternatives participant/client's attendant care services provider can perform medication assistance. The only way that a non-related attendant care services provider can perform medication assistance is when the Alternatives participant/client:

- is mentally capable of understanding what medication(s) he or she is taking, and
- is mentally capable of understanding the purpose of taking the medication and when the medication must be taken,

but, because of the participant/client's physical limitations, he or she can't actually get the medication out of its container and get it into his or her mouth. **If** the participant/client is mentally capable, based on the above, and:

- can tell the non-related provider that it is time to take his or her medication,
- can tell the non-related provider to open the medication container and get out the required amount of medication, and
- can tell the non-related provider to put the medication in his or her mouth,

the non-related attendant care services provider can dispense medication to the Alternatives participant/client.

Incidental housekeeping means cleaning of the floor and furniture **ONLY** in the room, space or location occupied by the Alternatives participant/client, for example, the participant/client's bedroom. Incidental housekeeping is hands-on assistance with waiver-covered tasks that the participant/client cannot physically perform him or herself. This does **NOT** mean cleaning the whole house if there are other household members in the house. If the participant/client lives in a house with other household members, the housework for the other members of the household **CANNOT** be done as part of Alternatives incidental housekeeping waiver services.

Incidental laundry means washing items incidental to the care of the Alternatives participant/client **ONLY**. It is hands-on assistance with covered laundry tasks, such as the participant/client's clothing, bed linens and towels that the participant/client cannot physically perform him or herself. This does **NOT** mean washing for the whole household. Washing laundry for other members of the household **CANNOT** be done as part of the Alternatives incidental laundry waiver services.

Shopping/Errand-s/Transportation:

Shopping means shopping **ONLY** for the Alternatives participant/client or assisting the participant/client with his or her shopping needs. It is hands-on assistance with covered tasks the participant/client cannot physically perform him or herself. This does **NOT** mean shopping for the whole household if there are other household members in the house.

Errands mean running errands **ONLY** for the Alternatives participant/client, such as picking up prescriptions at the pharmacy or shopping for the participant/client. This does **NOT** mean running errands for the whole household, if there are other household members in the house.

Transportation through the Alternatives waiver is non-medical transportation and is **ONLY** for the benefit of the Alternatives participant/client in his or her activities in accessing the community and would include such transportation as transporting participant/client to the grocery store for him or her to do shopping, transporting to activities like bingo, visiting a friend or community center. This does **NOT** mean transportation for the whole household, if there are other household members in the house.

Transportation to and from medical appointments is to be handled through the Arkansas Medicaid Transportation Program.

CLIENT SECTION

ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES WAIVER PROGRAM AGENCY ATTENDANT CARE SERVICE AGREEMENT

I, _____, as a client in the Alternatives for Adults with Physical Disabilities Waiver Program agree to the following:

- I understand that this agreement does not cover all participant/client responsibilities, and other information may be provided to me through other sources.
- I understand that State and Federal policy does not allow the provision of attendant care services through Alternatives to replace informal services already present in the home but is only intended to meet my unmet needs.
- I understand that in order to be eligible for the Alternatives Program I must receive Alternatives waiver services.
- I understand and agree to notify the Division of Aging & Adult Services immediately upon any change in my condition or circumstance including the termination of my Alternatives agency attendant care services provider.
- I understand that is my responsibility to participate in the assessment and reassessment process in order to establish and/or continue eligibility in the Alternatives program.
- I understand the restrictions with regards to the attendant care services of meal preparation; housework; laundry; non-medical transportation and catheter care and medication assistance (as these two services relate to the Nurse Practice Act).
- I understand that I shall instruct the Alternatives agency attendant care services attendant sent to me by the attendant care services agency on his or her duties and responsibilities to me and that I shall be responsible for maintaining accurate time records of agency attendant care services received by me. I understand that I must make these records available to the Alternatives attendant care services agency, Department of Human Services personnel and the Center for Medicare & Medicaid Services upon request for monitoring purposes. I understand that my failure to maintain accurate time records of agency attendant care services received by me or to make those records available to the Alternatives attendant care agency, the Department of Human Services personnel and the Center for Medicare & Medicaid Services upon request, could affect my continued participation in the Alternatives program.
- I understand and agree that my Alternatives agency attendant care services provider will not be responsible for providing any attendant care service(s) that are not specifically agreed upon by me and the agency attendant care services provider and listed on the plan of care.
- I understand that if my Alternatives agency attendant care services stop for any reason, I must report this to my Alternatives Counselor or RN immediately.
- I understand that if no waiver services are received by me for 30 consecutive days, my eligibility for the Alternatives program may be terminated.

- I understand that regardless of the date my Alternatives agency attendant care services begins, Medicaid reimbursement will not be allowed prior to the latter of the following:

    - the date Alternatives waiver eligibility begins for me, and
    - the date that both I and my Alternatives agency attendant care services provider representative sign this Agency Attendant Care Service Agreement (AAS-9512).

- I understand that the Agency Attendant Care Service Agreement (AAS-9512) must not be back dated.

- I understand that the Agency Attendant Care Service Agreement (AAS-9512) must be completed and signed by both me and my Alternatives agency attendant care services provider representative and postmarked within 14 calendar days of the date of the required signatures.

- I understand that if any actions on my part contribute to fraudulent billing occurring, the Department of Human Services will take appropriate legal action.

- I understand that it is my responsibility to inform my Alternatives Counselor or RN if I am going without agency attendant care services that are supposed to be performed by my agency attendant care services provider. If I fire my agency attendant care services provider or my agency attendant care services provider quits, I am to notify the Alternatives Counselor or RN immediately.

- I understand that if I change Alternatives agency attendant care services providers 6 or more times in a 12 month period or I am repeatedly unable to maintain a working relationship with agency attendant care services providers, I may be in danger of being removed from the Alternatives program.

- I understand that I cannot receive services through the Alternatives program while I am an inpatient in a hospital, nursing home or other institutional facility.

- I understand that I must inform the Alternatives Counselor or RN, **in writing**, in the event either my phone number or my address should change. If the telephone number that I have provided is the number of a person(s) who can get a message to me immediately, I will inform the Alternatives Counselor or RN, **in writing**, in the event that the person(s) telephone number(s) should change.

_____ _____

ALTERNATIVES PROGRAM CLIENT SIGNATURE Date

AGENCY ATTENDANT CARE SERVICES PROVIDER SECTION

ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES WAIVER PROGRAM AGENCY ATTENDANT CARE SERVICE AGREEMENT

I, _____, in order to participate in the Alternatives for Adults with Physical Disabilities Waiver Program as an Agency Attendant Care Services Provider agree to the following:

- I understand that this agreement does not cover all provider responsibilities, and other information may be provided to me through other sources.

- I understand that Alternatives is not a permanent Medicaid program and can end if the program is abused. I understand that I am required to act responsibly in order to protect the integrity of the Alternatives program. I understand that I can be removed from the Alternatives program if I disregard my responsibilities as an Alternatives agency attendant care services provider.

- I understand and agree that that I am neither entitled to nor will I make claim for any benefits from the Division of Aging & Adult Services including, but not limited to, workmen's compensation, disability, life or health insurance.

- I understand that in order to be Division of Aging & Adult Services certified and Medicaid enrolled as an Alternatives agency attendant care services provider, the attendants I employ to provide direct care to the Alternatives participant/client must meet the following minimum qualifications:

    - Be 18 years of age or older;
    - Be A United States citizen or legal alien authorized to work in the U. S.;
    - Be Free from evidence of:
        - abuse or fraud in any setting,
        - violations in the care of a dependent population,
        - conviction of a crime related to a dependent population, or
        - conviction of a violent crime;
    - Be free from communicable diseases;
    - Be free from diseases readily transmittable through casual contact;
    - Be able to read and write at a level sufficient to follow written instructions and maintain records;
    - Be in adequate physical health to perform job tasks required; and
    - Have a current signed formal agreement with an eligible Alternatives participant/client for the provision of agency attendant care services.

- I understand that as an agency attendant care services provider, I cannot hire/provide to the Alternatives participant/client an agency attendant care services employee/attendant who is legally responsible for the Alternatives participant/client.

- I understand and acknowledge that Division of Aging & Adult Services provider certification and Medicaid provider enrollment are for the sole purpose of providing Alternatives agency attendant care services to the Alternatives participant/client named as a party to this Agreement. I understand and acknowledge that Division of Aging & Adult Services provider certification and subsequent enrollment as a Medicaid provider of Alternatives agency attendant care services is contingent upon my satisfactory performance and annual renewal of this Agreement.

- I understand that regardless of the date I begin providing Alternatives agency attendant care services to the Alternatives participant/client, Medicaid reimbursement will not be allowed prior to the latter of the following:

    - the date my Alternatives participant/client's waiver eligibility begins, and
    - the date that both I and my Alternatives participant/client sign this Agency Attendant Care Service Agreement (AAS-9512).

- I understand that the Agency Attendant Care Service Agreement (AAS-9512) must not be back dated.

- I understand that the Agency Attendant Care Service Agreement (AAS-9512) must be completed and signed by both me and my Alternatives participant/client and postmarked within 14 calendar days of the date of the required signatures.

- I understand that I shall be responsible for scheduling and maintaining Alternatives agency attendant care services employee/attendant coverage, including the establishment of a written back-up plan in the event of my attendant care services employee/attendant's sickness, vacation or other absence. I understand to not have a backup plan is a reason to be removed from the Alternatives program as a provider.

- I understand and agree that no billing may be submitted for Alternatives agency attendant care services provided until I receive a Medicaid Provider Identification Number (PIN) and that my first check will not be mailed for at least two weeks after the first billing is submitted.

- I understand that I, as an Alternatives agency attendant care services provider, cannot mail, fax or hand deliver to EDS a billing claim prior to services actually being provided.

- I understand that as an Alternatives agency attendant care services provider, if I have a question regarding the completion of my billing claim form, I am to contact my area EDS provider assistance representative.

- I understand that as an Alternatives agency attendant care services provider, I am to complete a CMS-1500 billing claim form and submit to EDS for reimbursement of Alternatives agency attendant care services that I provide the Alternatives participant/client. I understand that if I want to make inquiry regarding the status of my billing claim that I am to call the EDS claim status toll free number 1-800-457-4454. I understand that information included on the EDS claim status toll free number changes each Monday.

- I understand that I am to keep a copy in my file of each Medicaid billing claim form (CMS 1500) that I submit to EDS for Medicaid reimbursement for Alternatives agency attendant care services that I provide my Alternatives participant/client.

- I understand that any actions on my part (e.g., billing for dates and hours that agency attendant care services were not actually provided; billing for future dates of service) that results in fraudulent billing occurring will result in my Alternatives agency attendant care services provider case being closed immediately. I understand that fraudulent billing practices will be sent to the appropriate parties responsible for Medicaid fraud.

- I understand and agree that I will not be responsible for providing any agency attendant care service(s) for the Alternatives participant/client that are not specifically agreed upon by both the Alternatives participant/client and me and was not listed on the Alternatives Plan of Care. I understand that I am to provide the agency attendant care service(s) according to the time schedule established by the Alternatives participant/client.

- I understand the restrictions with regards to the attendant care services of meal preparation; housework; laundry; non-medical transportation and catheter care and medication assistance (as these two services relate to the Nurse Practice Act).

- I understand and agree to provide Alternatives agency attendant care services in a safe, courteous and professional manner. I understand and acknowledge that any physical, sexual or mental abuse or neglect of the Alternatives participant/client by any attendant care services attendant(s) employed by me will result in the immediate termination of this Agreement and a report being made according to the mandates of Arkansas Code Ann. Section 5-28-101.

- I understand and agree to notify the Alternatives participant/client immediately in the event I am unable to provide the agreed Alternatives agency attendant care service(s).

- I understand that the agency attendant care services attendant(s) employed by me must maintain sufficient written documentation to support each Alternatives agency attendant care services that is provide the Alternatives participant/client for whom I submit billing for reimbursement through Medicaid. I understand failure to maintain sufficient documentation to support my billing practices may result in my having to pay back to Medicaid money that I received from Medicaid for payment. I understand that my failure to maintain sufficient documentation to support my billing practices could affect my continued participation in the Alternatives program.

- I understand that the agency attendant care services attendant(s) employed by me must keep a daily log providing a brief description of each agency attendant care service and the time that the each service was provided to the Alternatives participant/client. I understand that each daily entry in the log must be dated and signed by the agency attendant care services attendant(s) employed by me.

- I understand that I must keep all the required written documentation listed above for a period of 5 years from the date that the agency attendant care service was provided or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. I understand that I must make this written documentation available to authorized representatives of the Division of Aging & Adult Services, the Division of Medical Services, the state Medicaid Fraud Control Unit, representatives of the Center for Medicare & Medicaid Services and its authorized agents or officials.

- I understand that I must inform HP Enterprises, Provider Enrollment Unit, P. O. Box 709, Little Rock, AR 72203 **in writing**, in the event either my agency name, my phone number or my address should change.

_____ _____

AGENCY REPRESENTATIVE SIGNATURE DATE